TOWSON MEDICAL EQUIPMENT CO. INC.
Phone: 410-882-4005
Fax: 410-882-0056

SUBMITTED BY_____
PLEASE RETURN TO:

DURABLE MEDICAL EQUIPMENT
GENERIC PHYSICIAN'S ORDER FORM

Patient: _____ **Date of Birth:** _____
Address: _____
Phone#: _____ **Social Security #:** _____

Start Date/Initial Request _____

Date of current Illness (First Symptom) or Injury (Accident) _____

ICD-10 Diagnosis Code(s): _____

Underlying Condition(s): _____

Prognosis: _____

Treatment Plan: _____

Length of Need (0-99 months 99=lifetime):_____

QTY	HCPCS Code	R/P	Description of specific services to be provided	Charge	Allow

I, the undersigned, certify that the above prescribed supplies are medically necessary as part of my treatment plan for this patient and have not been prescribed as convenience.

Physician's Name: _____

Address: _____

Phone #: _____ **Fax#:** _____

UPIN#:_____ **Medical Assistance Provider #:** _____

Physician's Signature: _____ **Date:** _____